

System Transformation Initiative

American Indian Health Center
Spokane, Washington

MEETING NOTES

April 17, 2007

PRESENT: Joseph Waner, Kalispel Tribe; Gladys Yallop, Yakama Tribe; Linda Lauch, Sophie Tonasket and Judy Johnson; Indian Center, Cindy Robinson, and Sarah Jamison-Jeter, Native Project; Phil Ambrose and Bob Brisbois, Indian Policy; Andy Keller, Peter Selby, Jenifer Urff, and Maria Monroe-Devita, Consultants; Policy; Andy Toulon and Gaye Jensen, Mental Health Division

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ITA Presentation and Discussion:

- Need to integrate quality of care between the two governments (state and tribal)
- How much Tribal involvement is there in other state regarding ITA?
- One big issue is that different RSNs interpret the rules in different ways
- Public Law 280—Can compare various state to find a common thread
- Here, implementation is at the county level. We need to look at billing, codes, outcomes, etc. to make an analysis of the bigger picture
- There is not necessarily a correlation from a Tribal point of view. It will be hard to correlate changes at the top with outcomes at the “bottom”.
- There is a lot of research in Indian Country, but there are not a lot of changes at the level of implementation.

- Spokane county RSN meeting: they talked about culturally competent services; however, it was offensive because they did not recognize Tribal governments, and yet they bring in their own “experts”. They don’t ask us or contract with us. Our members need to have people who work with them who know Indian people.
- Age of consent—there is confusion about admitting if the child does not consent.
- There are not enough resources for children—capacity issue
- Is parental responsibility waived when youth consent? Are parents held accountable for the youth’s behavior? What about liability issues? What about the liability of the youth “self diagnosing” when they consent or don’t consent? Is there a potential for malpractice?
- Does confidentiality become an issue if there is a conflict between youth and parent?
- How are advanced directives determined? There seems to be a big challenge on distributing. How do people even know there is one? There are loopholes that address certain issues.
- We don’t have contracts with the RSNs (except for Kalispels) so we don’t know when an Indian person has been detained. This is a big disconnect.

Indian people come to Spokane from neighboring states (who have been dumped), and once they get Medicaid, they disappear into the RSN system and are lost to the Indian community.

How many Indian people are lost out there to jails, detention, LRAs, or are homeless?

- The term “culturally competent” is too broad.
- Intake processes need to ask if the person is a member of a Tribe, and then determine who the Tribal contact is. An emphasis needs to be on quality of care for the person. When referrals or discharge to the system is made, you need to ask again because the question may not have been integrated in the earlier process and the information lost. The question of Tribal membership needs to be asked at each stage.
- Are Tribes collecting data more effectively? DASA seems to have good Tribal data. There are some demographics gathered from the GAIN. We need to widen the demographics.

UBH collects data. MHD is not using them anymore. Is this data available?

- Important question—how to blend services for Native people involved with both Tribes and the RSN?

- People can be held for long periods of time based on misdiagnosis.
- These issues have been around a long time. Please don't mix up stakeholders with Tribes and Recognized American Indian Organizations!
- There is another big disconnect between mental health and chemical dependency. People with dual diagnosis suffer. The silos affect their services.
- We have to find a way to measure the best interests of the client and evaluate if they are being met. It is the mutual responsibility of everyone to meet the needs of the client. When you have a limited revenue base, there is a tendency to protect it, and the client may not get what they need.
- What would be a good outcome for ITA reform from the Tribal government perspective?
 - MOUs and MOAs that recognize Tribal court orders
 - Recognition of the expertise of Tribal staff.
 - Establishment of a pathway for better access to care

There has been some experience with memos of collaboration for voluntary care.

- It can take hours for the mental health professional to get out to the reservation. Timeliness is a big issue. Sometimes people have to wait up to 8 hours for an assessment—this is not okay.
- Each Tribe is unique in all circumstances and can't speak globally about all the other Tribes. This type of thinking is part of the disconnect.
- Learning boundaries is very important to understanding the issues. Indian people can't trust if they know that people haven't learned about individual Tribes and RAIOS and the fact that they can speak only within prescribed boundaries.
- Roles of Participants in today's meeting:
 - Linda is from the American Indian Center. They don't have a mental health program which is a concern to them. They serve people who have been "lost". They are not Tribal, but an RAIOS. They serve people who belong to various Tribes with govt.-to-govt. relationships. Linda is the employment and training manager.
 - Bob is a member of the Spokane Tribe and works for DSHS, Indian Policy. His wife is a Colville member.
 - Judy is the education director for youth served by the American Indian Center.
 - Cindy is from Native Health which serves mostly female adults and Native Project which has a program for teens. She has a masters degree in social work and has a background in chemical dependency and mental health. She was on an ACT Team in Coeur d'Alene, Idaho. She is dedicated to helping people receive the services to which they are entitled.

- Gladys is from the Yakama Nation and is an assistant to her boss who manages the Emergency Assistance Program. Mental health services are moving to the Tribe.
- Phil is a member of the Yakama Tribe and works for DSHS Indian Policy. He assists with helping people to receive services. He was formerly a grants and contracts manager for the Yakama's. He is concerned with "not reinventing the wheel", but coordinating and integrating services.
- Sara is from Native Project in Spokane. She supervises child and adolescent services. She has sat in on a number of initiatives. It seems to her that we continue to tell people what doesn't work, but nothing changes!
- Joseph is from the Kalispel Tribe. He supervises mental health and chemical dependency. His Tribe has a contract with the RSN and for CD. He is a victim's advocate and involved with employee assistance, men's work, and domestic violence issues. He wears many hats and loves this area and what he does.
- Ben is the Behavior health Program Manager with the Colville Tribe. He has an outpatient CD program, Title 19 mental health, and crisis services. They have a big geographical area to cover.

Medicaid Benefits Package Presentation and Discussion:

- Medicaid benefit package categories don't bridge over instantly to the Tribal service delivery system and what it needs. Administrative layers take away from direct service delivery.
- Federal Medicaid—state—counties—providers have to find a way to accommodate the clients' treatment plans. The service may exist at the federal level, but not be in the State Plan, etc. We need to have the right codes.
- RFPs get sent out but not to Tribes and RAIOS. We're not even considered. We can't advocate when we don't know the numbers of people in jail, etc. It's very frustrating to know that there are people not getting what they need because we can't advocate for them.
- Some Indian people have nothing to do with RSNs, or RSN contracted case managers don't even contact us.
- Compare our (RAIOS) salaries with RSNs, and the State. We're pretty simple and basic. We do what an ACT Team does. We do a lot of wellness and prevention. We are not just "mental health"; we are COMMUNITY. We are the experts, the ones that know what fits people's needs. The predominant culture does not recognize what we can do. We are responsible to the Indian community.
- We have been talking about the same issues for a long time. What good does it do to try to integrate into the RSN system? We don't have fancy offices with waterfalls, but we are there for people.
- Yakama is beginning a mental health program.

- A more direct relationship with the state might work better. We shouldn't have to fight with the RSN. It's a problem working between two system, as well as, problems between individuals.
- The community model we use is evidence-based!
- If communication locally is hard, what about the Olympia! Perhaps there should be some sort of overseer of RSNs.
- EBPs—whose science is it based on? Medicine Wheel and White Bison, for example, are best practices.
- Traditional medicine (Native American), the seat lodge, and elder wisdom are also important methods for Indians. We would like to see a coalition of state and native people develop a list of Tribal practices that we know work that can be called best or promising practices. We want to be able to bill for encounters that include traditional methods.

PACT Prevention/Discussion:

- There are a lot of Indian people living in the areas identified for PACT Teams. We have not heard of any invitations from RSNs about PACT involvement.
- In Spokane it was not economically feasible for a small non-profit to participate in planning meetings
- Is there a duplication of services that are provided by RAIOS or reservations?
- Why invent a new wheel?
- Not sure Indian people will want to participate in PACT. Will PACT understand the experiences, like boarding school, that Indian people have gone through?
- American Indian Center does most of the things that a PACT Team does, although they aren't funded for it. Indian people are more likely to go where the people know them.
- There should be a Native American PACT Team!
- The more severe the illness and disability, the greater the mistrust. People want to be around people who look like them.
- It is not a problem to hire qualified Indian people to be involved.
- Building relationships in the Indian Community is the key (like it is in PACT).
- Cultural competence and consultation is more than checking a box.

- Lots of clients end up out of the service delivery system because of jurisdiction issues. You miss the individual service plan.
- You need to be sure to include “consultation” (from the 7.01 Plan) in PACT implementation.
- Unfunded supports are the natural supports and vice versa. Why can’t these things be funded?
- PACT services are things that the Tribes all naturally do—it’s a way of life

Other Comments:

- Tribal TANF data might be helpful for determining data regarding Indian people
- Federal government developed Tribal codes—Washington has been working on converting to a single combined code
- Need to remember that not all Indian people are enrolled.
- Recommend: Figuring out how to reimburse services provided by Tribes and RAIOS for which codes have not been identified. This could be in the form of developing a cross-walk to the right codes.
- Need to balance the resources on a global basis.
- There is a way to fit culture and tradition into everything—try looking at New Mexico who has done this